

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2696

## CERTIFICATE OF DEATH

Reg. Dist. No. 02685

1. PLACE OF DEATH a. COUNTY Worcester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin		c. LENGTH OF STAY IN lb lyr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Ocean City					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Berlin Nursing Home				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) NORA		First	Middle	Lost	4. DATE OF DEATH Feb. 17, 1960	Month	Day	Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. B. DATE OF BIRTH March 15, 1875	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Savage				14. MOTHER'S MAIDEN NAME Margaret (Unknown)					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) XX		16. SOCIAL SECURITY NO. XX		17. INFORMANT Ranzie Benson		Address Bishop, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 422.2 Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause last. (b) (c)		DUE TO Acute Heart attack				INTERVAL BETWEEN ONSET AND DEATH 2 mo			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Bishopville	(County)	(State)	
21. I certify that I attended the deceased from		Jan 2 - 1960, to Feb 17 - 1960		that I last saw the deceased alive on Feb 17 - 1960, and that death occurred at 4:30 PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Bishopville, Md.		DATE SIGNED Feb 18 - 1960	
ACTUAL SIGNATURE Char. R. Lain									
PHYSICIAN'S NAME (Type) Burke									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/20/60		22c. NAME OF CEMETERY OR CREMATORIAL Zion Church Yard		22d. LOCATION (City, town, or county) Bishopville, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley		ADDRESS		24a. REC'D BY REGISTRAR FEB 23 '60		24b. REGISTRAR'S SIGNATURE Charles S. Hayes			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

СЕВЕРНО-ЗАПАДНЫЙ ФЕДЕРАЛЬНЫЙ ОКРУГ

## 1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2700

## CERTIFICATE OF DEATH

Reg. Dist. No.

02686

1. PLACE OF DEATH o. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 909 Clarke Avenue		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42 Pocomoke City	
3. NAME OF DECEASED (Type or print) Joe		d. STREET ADDRESS 909 Clarke Avenue	
4. DATE OF DEATH February 9, 1960.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 16, 1863
9. AGE (In years lost birthday) 97 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Oyster	
10c. BIRTHPLACE (State or foreign country) Accomack County, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME (Unknown)		14. MOTHER'S MAIDEN NAME (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. N one	
17. INFORMANT Son, Charles J. Matthews, Pocomoke City, Md.		Address 909 Clarke Ave., Pocomoke City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Degenerative Heart Disease (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Extreme old age. atrophic changes.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 6, 1960, to Feb. 9, 1960, that I last saw the deceased alive on Feb. 8, 1960, and that death occurred at 10:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Charles W. Trader, M.D. ACTUAL SIGNATURE Physician's Name (Type) Charles W. Trader, M.D., 302 Market Street, Pocomoke City, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/14/60	
22c. NAME OF CEMETERY OR CREMATORIAL John W. Taylor Memorial Cemetery		22d. LOCATION (City, town, or county) Severna Park, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. Richard Johnson		24a. REC'D BY REGISTRAR FEB 15 '60	
ADDRESS Parksley, Va		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

Date of Birth

Cause of Death

Place of Death

Date of Death

Name of Physician

Name of Hospital

Name of Mortician

Age at Death

Name of City

Name of State

Name of Country

Sex

Name of Street

Race

Name of City

Marital Status

Name of City

Occupation

Name of City

Employer

Name of City

Employer's Address

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2705

## CERTIFICATE OF DEATH

Reg. Dist. No.

02687

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SHOWGULLS</b>		c. LENGTH OF STAY IN 1b <b>69 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X SHOWGULLS</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First <b>JOHN</b>	Middle <b>THOMAS</b>
Last <b>MUMFORD</b>		4. DATE OF DEATH Month <b>Feb.</b>	Day <b>22</b>
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>APRIL 20, 1890</b>		9. AGE (In years lost birthday) <b>69 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>	
11. BIRTHPLACE (State or foreign country) <b>BERLIN MD (RFD)</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS MUMFORD</b>		14. MOTHER'S MAIDEN NAME <b>ANNE MARIAH CLARK.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-12-5102</b>	
17. INFORMANT <b>Mr. C. T. L. Mumford</b>		Address <b>SHOWGULL MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocarditis (acute)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>492X</b>		DUE TO <b>Atypical pneumonia</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) <b>None</b>		DUE TO <b>None</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>Jan. 14, 1960</b> , to <b>Feb. 22, 1960</b> , that I last saw the deceased alive on <b>Feb. 21, 1960</b> , and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>Frank Lewis</b>		ADDRESS (Street, city or town, state) <b>Willards, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Frank R. Lewis M.D.</b>		DATE SIGNED <b>2/23/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/26/60</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>LEWIS</b>		22d. LOCATION (City, town, or county) <b>WILMINGTON (RFD) MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna A. Bubage Berlin Md</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 1 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

ADMITTED TO EXAMINATIONS  
BY THE STATE OF NEW YORK

ANNUAL EXAMINATIONS  
IN THE STATE OF NEW YORK

87

87

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2701

## CERTIFICATE OF DEATH

Reg. Dist. No.

02688

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. LENGTH OF STAY IN 1b 22 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 121 Sixth Street		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City	
3. NAME OF DECEASED (Type or print) ASHER		First GREENSBORO	Middle PARSONS
4. DATE OF DEATH February	Month 11	Day Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 23, 1892
9. AGE (In years lost birthday) 68 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor	10b. KIND OF BUSINESS OR INDUSTRY Lumber	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Sidney Parsons		14. MOTHER'S MAIDEN NAME Leona Figgs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. --	17. INFORMANT Mrs Ruth V. Parsons, Pocomoke City, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3 MUNS. CARCINOMATOSIS	
(b) DUE TO C. (c)		BRONCHOGENIC CARCINOMA RIGHT LUNG 2 YEARS	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. p.m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>FEB 18</u> , 19 <u>56</u> to <u>FEB 11</u> , 19 <u>60</u> that I last saw the deceased alive on <u>FEB. 11</u> , 19 <u>60</u> , and that death occurred at <u>5:15 A.M.</u> from the causes and on the date stated above.	ADDRESS (Street, city or town, state) C. STANFORD HAMILTON, M.D. 22 MARKET ST.		DATE SIGNED 2/12/60
ACTUAL SIGNATURE C. STANFORD HAMILTON	M.D.		
PHYSICIAN'S NAME (Type) C. STANFORD HAMILTON, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-13-60	22c. NAME OF CEMETERY First Baptist	22d. LOCATION (City, town, or county) Pocomoke City, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Henry Watson	ADDRESS Pocomoke City, Md.	24a. REC'D BY REGISTRAR DATE FEB 15 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MICHIGAN STATE GOVERNMENT OF MICHIGAN - BUREAU OF MOTOR VEHICLES

## CERTIFICATE OF DESIGN

1953

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4  
 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**2702 CERTIFICATE OF DEATH**

Reg. Dist. No. 02689

1. PLACE OF DEATH a. COUNTY <b>Worcester</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>		c. LENGTH OF STAY IN 1b <b>7 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1511 Market Street</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>	
3. NAME OF DECEASED (Type or print) <b>DR. FRED W. PARSONS</b>		4. DATE OF DEATH Month <b>February 13 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 19, 1923</b>
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) <b>36 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dentist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self-employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Arthur W. Parsons</b>		14. MOTHER'S MAIDEN NAME <b>Hurley Parsons</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>233-34-0542</b>	
		17. INFORMANT <b>Mrs Evelyn Parsons, Pocomoke City, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <b>420.1</b>			
(b) <b>Coronary Artery Disease</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>1511 Market Street</b> (County) <b>Pocomoke City</b> (State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>June 22, 1959</b> to <b>Feb. 13, 1960</b> , that I last saw the deceased alive on <b>Feb. 11, 1960</b> , and that death occurred at <b>602P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles W. Trader</i>		ADDRESS (Street, city or town, state) <b>302 Market Street, Pocomoke City, Md.</b>	
DATE SIGNED <b>Feb. 15, 1960</b>			
PHYSICIAN'S NAME (Type) <b>Charles W. Trader, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-18-60</b>	
22c. NAME OF CEMETERY OR BURIAL PLACE <b>First Baptist</b>		22d. LOCATION (City, town, or county) <b>Pocomoke City, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry S. Watson</i>		24a. REC'D. BY REGISTRAR <b>FEB 23 '60</b>	
		24b. REGISTRAR'S SIGNATURE <i>Charles S. Trahan</i>	

CEMETERY OF DEATH

WISCONSIN STATE DEVELOPMENT

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 02600

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>		c. LENGTH OF STAY IN 1b <b>All his Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Route # 2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Albert</b>		First <b>Albert</b>	Middle <b>Purnell</b>
4. DATE OF DEATH Month <b>2</b>	Day <b>19</b>	Year <b>1960</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>AA</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 10, 1854</b>
9. AGE (In years last birthday) <b>105 yrs.</b>	10. IF UNDER 1 YEAR Months <b>-</b>	11. IF UNDER 24 HRS. Days <b>-</b>	12. IF UNDER 24 HRS. Hours <b>-</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>L. H. Purnell</b>		14. MOTHER'S MAIDEN NAME <b>Mahalia - Purnell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>NO</b>	
17. INFORMANT <b>Mrs. Roxie Bailey, OCEAN CITY, M.D.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertension</b> DUE TO <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>several years</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Senility</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-23</b> , 19 <b>59</b> , to <b>2/19</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>2/19</b> , 19 <b>60</b> , and that death occurred at <b>1145 M</b> , from the causes and on the date stated above.		ADDRESS (Street, city, or town, state) <b>Berlin Md</b>	
ACTUAL SIGNATURE <b>Ivory U. Sully, Jr., M.D.</b>		DATE SIGNED <b>2-22-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-23-60</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>EVERGREEN CEM.</b>		22d. LOCATION (City, town, or county) <b>BERLIN</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thornton B. Jolley, Salisbury, Md</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 29 60</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Thornton B. Jolley</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be relied on by the hospital or attending physician  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2703

## CERTIFICATE OF DEATH

Reg. Dist. No.

02691

1. PLACE OF DEATH a. COUNTY <b>Worcester</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>		c. LENGTH OF STAY IN 1b <b>20 years</b>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OR INSTITUTION <b>213 Maple Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>ARTHUR</b>	Middle <b>D.</b>	Last <b>SCHOOLFIELD</b>
4. DATE OF DEATH	Month <b>February</b>	Day <b>24</b>	Year <b>1960</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>March 5, 1895</b>
8. ADDRESS <b>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></b>	9. AGE (In years lost birthday) <b>64 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Canning Co.</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Samuel Schoolfield</b>	14. MOTHER'S MAIDEN NAME <b>Fannie Johnson</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>	16. SOCIAL SECURITY NO. <b>WW #1</b>	17. INFORMANT <b>217-09-1721 Mrs Gertrude Schoolfield, Maryland</b>	Address <b>Pocomoke City, Maryland</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary thrombosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 hr</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <b>Generalized atherosclerosis</b> 8-9 mths			
DUE TO <b>Ess Hypertension</b> 8-12 mths			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>12-1-1960</b> to <b>2-24-1960</b> , that I last saw the deceased alive on <b>2-24-60</b> , and that death occurred at <b>7:50 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Cecil A. Duverney, M.D.</i>	ADDRESS (Street, city or town, state) <b>801-4th St, Pocomoke</b>		
PHYSICIAN'S NAME (Type) <b>CECIL A. DUVERNEY, M.D.</b>	DATE SIGNED <b>2/27/60</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-28-60</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Halls Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Pocomoke City, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry S. Watson</i>	ADDRESS <b>Pocomoke City, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>FEB 29 '60</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>

## WISCONSIN STATE DEPARTMENT OF HEALTH AND REHABILITATION

## CERTIFICATE OF DEATH

100-100

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**2706 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02692

1. PLACE OF DEATH a. COUNTY <b>Worcester</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Whaleyville</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>At home</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Whaleyville</b>	
3. NAME OF DECEASED (Type or print) <b>DANIEL</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>12</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>June 1, 1873</b>	9. AGE (In years last birthday) <b>86</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lumber</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>William Henry Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Mariah Niblett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>XX</b>		16. SOCIAL SECURITY NO. <b>220-16-9917</b>	17. INFORMANT Address <b>Beulah Lewis Whaleyville, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
<p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gunshot Wound resulting in complete</i> <i>976X</i> <i>scars</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>slitting of scut &amp; evulsion of Brain tissue</i> DUE TO (c)</p>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Suicide</i>	
20c. TIME OF INJURY Hour <b>10</b> o. m. p. m. <b>2/12/1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>
20f. (City or town) <b>Whaleyville Worcester Md</b>		(County) <b>Worcester</b>	(State) <b>Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Beulah Lewis</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <i>2/13/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/14/60</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Whaleyville</b>
22d. LOCATION (City, town, or county) <b>Whaleyville Md</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Peter Whaley Whaleyville Del.</i>		ADDRESS <b>Whaleyville Del.</b>	24a. REC'D BY REGISTRAR DATE FEB 16 '60
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>

MELODIA EXHIBITION IN CELEBRATION OF THE 200TH ANNIVERSARY OF HANDEL'S BIRTH

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2693

## CERTIFICATE OF DEATH

Reg. Dist. No.

12693

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retyped by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>WORCESTER</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>		c. LENGTH OF STAY IN 1b <b>69 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X BERLIN</b>		d. STREET ADDRESS <b>TAYLORVILLE (RURAL)</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>EDWARD</b>	Middle <b>BURTON</b>	Last <b>TRUITT</b>	4. DATE OF DEATH <b>FEB. 8 1960</b>	Month <b>FEB.</b>	Day <b>8</b>	Year <b>1960</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 9, 1890</b>	9. AGE (In years lost birthday) <b>69 yrs.</b>	IF UNDER 1 YEAR Months <b>69</b>	IF UNDER 24 HRS. Days <b>69</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BROILER</b>		11. BIRTHPLACE (State or foreign country) <b>BERLIN MD (RFD)</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>ZADOC TRUITT</b>		14. MOTHER'S MAIDEN NAME <b>MARY JANE SARVIS</b>		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-34-7571</b>		17. INFORMANT <b>MRS. BURT TRUITT, BERLIN MD RFD</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> DUE TO <b>420.1</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Artery Disease</b> DUE TO (c)						<b>4-6 mo</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>BERLIN</b> (County) <b>MARYLAND</b> (State)		
21. I certify that I attended the deceased from <b>Feb. 8, 1960</b> to <b>Feb. 8, 1960</b> , that I last saw the deceased alive on <b>Feb. 8, 1960</b> , and that death occurred at <b>7:45 AM</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>Berlin, Md.</b>		DATE SIGNED <b>2/10/60</b>		
ACTUAL SIGNATURE <b>Hannah Robbin</b>								
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/10/60</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>TAYLORVILLE</b>		22d. LOCATION (City, town, or county) (State) <b>BERLIN MARYLAND</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna A. Burbage Berlin Md</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>FEB 15 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Pearce</b>		



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2639

## CERTIFICATE OF DEATH

Reg. Dist. No.

02694

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>		c. LENGTH OF STAY IN 1b <b>1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X BERLIN</b>	
3. NAME OF DECEASED (Type or print) <b>CHARLES PATTON</b>		First <b>V</b>	Middle <b>VENABLE</b>
4. DATE OF DEATH <b>FEB. 23 1960</b>		Month <b>FEB.</b>	Day <b>23</b>
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>JAN. 22, 1874</b>		9. AGE (in years last birthday) <b>86 yrs.</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>86</b> yrs. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DRY CLEA</b> NGER		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FIRM</b>	
11. BIRTHPLACE (State or foreign country) <b>JONESBORO, VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DRURY W. VENABLE</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH ANDERSON PATTON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-26-3565</b>	
17. INFORMANT <b>Mr. W. M. VENABLE</b>		Address <b>BERLIN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>431X</b>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <b>acute myocarditis</b>			
(c) DUE TO <b>Chronic Neuropathy</b>			
(d) DUE TO <b>Senility</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-1 1960</b> to <b>2-23 1960</b> , at <b>Berlin MD.</b> that I last saw the deceased alive on <b>2-23 1960</b> , and that death occurred at <b>10 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Berlin MD.</b> DATE SIGNED	
ACTUAL SIGNATURE <b>Clifford E. Schott M.D.</b>		PHYSICIAN'S NAME (Type) <b>CLIFFORD E. SCHOTT</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/25/60</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>EVERGREEN</b>		22d. LOCATION (City, town, or county) <b>BERLIN</b> (State) <b>MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna R. Burbage Berlin MD.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 29 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	

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**TO HOSPITAL**  **ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours of death. Page 4  
**TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2707

## CERTIFICATE OF DEATH

Reg. Dist. No.

02695

1. PLACE OF DEATH o. COUNTY <b>Worcester</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Pocomoke</b>		c. LENGTH OF STAY IN 1b c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D. # 2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EUNICE</b>		First <b>FRANCES</b>	Middle <b>WILLIAMS</b>
Last <b>WILLIAMS</b>		4. DATE OF DEATH <b>FEB. 3rd</b>	Month Day Year <b>19 60</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee-Restaurant</b>		9. DATE OF BIRTH <b>Aug. 17, 1923</b>	
10. KIND OF BUSINESS OR INDUSTRY <b>Waitress</b>		11. BIRTHPLACE (State or foreign country) <b>Worcester Co. Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Elmer F. McGrath</b>	
14. MOTHER'S MAIDEN NAME <b>Mildred Amanda Townsend</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>Mr Elmer Lee Williams (Husband)</b>		INFORMANT <b>402 Market St. Pocomoke, Maryland</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 Mo.</b>	
174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma, uterus</b>		12 Mo.	
18. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 11, 1959</b> , to <b>Feb. 3, 1960</b> that I last saw the deceased alive on <b>Feb. 3, 1960</b> , and that death occurred at <b>4:55 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Charles W. Trader</b> M.D.	
ACTUAL SIGNATURE <b>Charles W. Trader</b>		DATE SIGNED <b>Feb. 5 1960</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Charles W. Trader</b>		302 Market St Pocomoke, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 7 1960</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Worcester Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 8 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Trahan</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2704

## CERTIFICATE OF DEATH

Reg. Dist. No.

02696

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pocomoke</i>		c. LENGTH OF STAY IN 1b RURAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Worcester</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pocomoke, md</i>		d. STREET ADDRESS <i>723 - 615 ST.</i>			
3. NAME OF DECEASED (Type or print) <i>ALINE</i>		First <i>ALINE</i>	Middle <i>Winslow</i>	Last <i></i>	4. DATE OF DEATH <i>Feb. 1st</i>	Month <i>Feb.</i>	Day <i>1</i>	Year <i>1960</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 10, 1890</i>	9. AGE (In years last birthday) <i>69</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Womans</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housework</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>John Mills</i>		14. MOTHER'S MAIDEN NAME <i>Arabella Harmon</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>Madeline Long - Pocomoke, md.</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Cerebrovascular Accident				INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>			
		Generalized arteriosclerosis				4 yrs.			
		Essential hypertension				5 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Dehydration &amp; Electrolyte imbalance</i>							
20c. TIME OF INJURY Month, Doy, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>6-25-</i> , 19 <i>58</i> , to <i>2-1-</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>1-31-</i> , 19 <i>60</i> , and that death occurred at <i>415 M</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Cecil R. Duvemey</i>						ADDRESS (Street, city or town, state) <i>801-4th Pocomoke City, md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-7-60</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Cool Spring</i>		22d. LOCATION (City, town, or county) (State) <i>Grind Tree, md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar Wharton - Newchurch, Va.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>FEB 9 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>			

